		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043711

Facility Name: OAKWOOD HEALTH CARE CENTER

Address: 605 E. CHURCH ST., P.O. BOX 60 (Number) KEWANEE (City) 61443 (Zip Code)

County: HENRY

Telephone Number: (309) 852-3389 **Fax #** (309) 853-1838

IDPA ID Number: 830320180018

Date of Initial License for Current Owners: 02/07/98

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: JEFFREY E. BOLAND **Telephone Number:** (717) 213-3125

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) LARRY BONDS
(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) JEFFREY E. BOLAND, DIRECTOR
(Firm Name & Address) ZA CONSULTING, LLC, 305 NORTH FRONT STREET, HARRISBURG, PA 17101
(Telephone) (717) 213-3125 Fax # (717) 233-4633

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,361	6,754	2,485	38,600	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,361	6,754	2,485	38,600	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.73%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/7/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/7/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2,485

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	167,293	22,433	7,058	196,784		196,784	(7,447)	189,337			1
2	Food Purchase		165,038		165,038		165,038		165,038			2
3	Housekeeping	79,115	13,919	117	93,151		93,151		93,151			3
4	Laundry	69,295	13,118		82,413		82,413		82,413			4
5	Heat and Other Utilities			128,981	128,981		128,981		128,981			5
6	Maintenance	37,450	18,123	39,814	95,387		95,387		95,387			6
7	Other (specify):*											7
8	**TOTAL General Services**	353,153	232,631	175,970	761,754		761,754	(7,447)	754,307			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	950,169	65,513	60,606	1,076,288		1,076,288	7,006	1,083,294			10
10a	Therapy	2,012		74,204	76,216		76,216		76,216			10a
11	Activities	37,284	869	2,290	40,443		40,443		40,443			11
12	Social Services	40,450		2,290	42,740		42,740	84	42,824			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,029,915	66,382	151,390	1,247,687		1,247,687	7,090	1,254,777			16
	C. General Administration											
17	Administrative			69,261	69,261		69,261	24,784	94,045			17
18	Directors Fees											18
19	Professional Services			3,881	3,881		3,881	113,878	117,759			19
20	Dues, Fees, Subscriptions & Promotions			21,491	21,491		21,491	(17,005)	4,486			20
21	Clerical & General Office Expenses	78,820	12,336	85,427	176,583		176,583	(18,163)	158,420			21
22	Employee Benefits & Payroll Taxes			139,193	139,193		139,193	92,842	232,035			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,396	12,396		12,396	5,486	17,882			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,620	68,620		68,620	34,648	103,268			26
27	Other (specify):*											27
28	**TOTAL General Administration**	78,820	12,336	400,269	491,425		491,425	236,470	727,895			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,461,888	311,349	727,629	2,500,866		2,500,866	236,113	2,736,979			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER #0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			230,820	230,820		230,820		230,820			30
31	Amortization of Pre-Op. & Org.			219,263	219,263		219,263	(212,527)	6,736			31
32	Interest			257,911	257,911		257,911		257,911			32
33	Real Estate Taxes			54,356	54,356		54,356		54,356			33
34	Rent-Facility & Grounds			178,908	178,908		178,908		178,908			34
35	Rent-Equipment & Vehicles			9,574	9,574		9,574		9,574			35
36	Other (specify):* Mtg Guarantee			43,246	43,246		43,246		43,246			36
37	**TOTAL Ownership**			994,078	994,078		994,078	(212,527)	781,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,374	45,261	91,635		91,635		91,635			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,800	109,800		109,800		109,800			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		46,374	155,061	201,435		201,435		201,435			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,461,888	357,723	1,876,768	3,696,379		3,696,379	23,586	3,719,965			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,447)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(276,007)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (283,454)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	306,986	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 306,986		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 23,532		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAKWOOD HEALTH CARE CENTER

ID# 0043711

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	AMORT - GOODWILL	(212,527)	31	2
3	EXTRAORDINARY ITEMS	(10,000)	21	3
4	FINES / PENALTIES	(24,230)	21	4
5	BANK CHARGES	(46)	21	5
6	BUSINESS MEALS	(12,145)	21	6
7	PUBLIC RELATIONS	(17,005)	20	7
8				8
9				9
10				10
11				11
12				12
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87				87
88				88
89				89
90	**Total**	(275,953)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(7,447)	0	0	0	0	0	0	0	0	0	0	(7,447)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,447)	0	0	0	0	0	0	0	0	0	0	(7,447)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,006	0	0	0	0	0	0	0	0	0	7,006	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	84	0	0	0	0	0	0	0	0	0	84	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	7,090	0	0	0	0	0	0	0	0	0	7,090	16
	C. General Administration													
17	Administrative	0	24,784	0	0	0	0	0	0	0	0	0	24,784	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	113,878	0	0	0	0	0	0	0	0	113,878	19
20	Fees, Subscriptions & Promotions	(17,005)	0	0	0	0	0	0	0	0	0	0	(17,005)	20
21	Clerical & General Office Expenses	(46,421)	3,106	25,152	0	0	0	0	0	0	0	0	(18,163)	21
22	Employee Benefits & Payroll Taxes	0	0	92,842	0	0	0	0	0	0	0	0	92,842	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,486	0	0	0	0	0	0	0	0	0	5,486	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	34,648	0	0	0	0	0	0	0	0	34,648	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(63,426)	33,376	266,520	0	0	0	0	0	0	0	0	236,470	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,873)	40,466	266,520	0	0	0	0	0	0	0	0	236,113	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(212,527)	0	0	0	0	0	0	0	0	0	0	(212,527)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(212,527)	0	0	0	0	0	0	0	0	0	0	(212,527)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(283,400)	40,466	266,520	0	0	0	0	0	0	0	0	23,586	45

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		SEE ATTACHED LIST		Eden & Associates	Wilson, WY	Consulting

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Contract Services - RN	$	Senior Living Properties, LLC	100.00%	$ 745	$ 745	1
2	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	2,862	2,862	2
3	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	3,399	3,399	3
4	V	12	Social Services Consultant	2,290	Senior Living Properties, LLC	100.00%	2,374	84	4
5	V	17	Contract Services - Business Office	38,553	Senior Living Properties, LLC	100.00%	54,841	16,288	5
6	V	17	Contract Services - Administrator	30,708	Senior Living Properties, LLC	100.00%	39,204	8,496	6
7	V	24	Travel	12,114	Senior Living Properties, LLC	100.00%	17,346	5,232	7
8	V	21	Business Meals	12,145	Senior Living Properties, LLC	100.00%	12,615	470	8
9	V	24	Seminars	282	Senior Living Properties, LLC	100.00%	536	254	9
10	V	21	Office Supplies	4,114	Senior Living Properties, LLC	100.00%	4,810	696	10
11	V	21	Supplies	6,608	Senior Living Properties, LLC	100.00%	6,742	134	11
12	V	21	Postage	1,613	Senior Living Properties, LLC	100.00%	1,640	27	12
13	V	21	Telephone	28,566	Senior Living Properties, LLC	100.00%	30,345	1,779	13
14	Total			$ 136,993			$ 177,459	$ * 40,466	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	EDP Services	$	Senior Living Properties, LLC	100.00%	$ 7,889	$ 7,889	15
16	V	19	Legal Fees	1,086	Senior Living Properties, LLC	100.00%	16,466	16,466	16
17	V	19	Accounting Fees	2,795	Senior Living Properties, LLC	100.00%	33,638	32,552	17
18	V	26	Insurance - General Liability	62,660	Senior Living Properties, LLC	100.00%	8,682	5,887	18
19	V	26	Insurance - Property & Contents	5,559	Senior Living Properties, LLC	100.00%	89,695	27,035	19
20	V	26	Insurance - Other	400	Senior Living Properties, LLC	100.00%	5,803	244	20
21	V	22	Workers Compensation Claims	24,901	Senior Living Properties, LLC	100.00%	7,769	7,369	21
22	V	22	Health & Dental Insurance		Senior Living Properties, LLC	100.00%	50,726	25,825	22
23	V	21	Management Fees		Senior Living Properties, LLC	100.00%	38,443	38,443	23
24	V	19	Legal Fees		Senior Living Properties, LLC	100.00%	797	797	24
25	V	22	Workers Compensation Claims		Senior Living Properties, LLC	100.00%	75,439	75,439	25
26	V	21	Management Fees		Senior Living Properties, LLC	100.00%	28,574	28,574	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 97,401			$ 356,032	$ * 266,520	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 3395 North Pines Drive, Suite 102
City / State / Zip Code: Wilson, Wyoming, 83014
Phone Number: (307) 739-1209
Fax Number: (307) 739-1217

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (Il Only)	675,434	31	$ 13,034	$	38,600	$ 745	1
2	10	Contract Services - RN	Resident Days (Il Only)	675,434	31	50,078		38,600	2,862	2
3	10	Contract Services - RN	Resident Days (Il Only)	675,434	31	59,476		38,600	3,399	3
4	12	Social Services Consultant	Resident Days (Il Only)	675,434	31	1,475		38,600	84	4
5	17	Contract Services - Business Offic	Resident Days (Total)	1,728,555	87	729,382		38,600	16,288	5
6	17	Contract Services - Administrator	Resident Days (Il Only)	675,434	31	148,670		38,600	8,496	6
7	24	Travel	Resident Days (Il Only)	675,434	31	91,552		38,600	5,232	7
8	21	Business Meals	Resident Days (Il Only)	675,434	31	8,225		38,600	470	8
9	24	Seminars	Resident Days (Il Only)	675,434	31	4,452		38,600	254	9
10	21	Office Supplies	Resident Days (Il Only)	675,434	31	12,185		38,600	696	10
11	21	Supplies	Resident Days (Il Only)	675,434	31	2,350		38,600	134	11
12	21	Postage	Resident Days (Il Only)	675,434	31	466		38,600	27	12
13	21	Telephone	Resident Days (Il Only)	675,434	31	31,125		38,600	1,779	13
14	21	EDP Services	Resident Days (Il Only)	675,434	31	138,040		38,600	7,889	14
15	19	Legal Fees	Resident Days (Total)	1,728,555	87	737,379		38,600	16,466	15
16	19	Accounting Fees	Resident Days (Total)	1,728,555	87	1,457,713		38,600	32,552	16
17	26	Insurance - General Liability	Resident Days (Total)	1,728,555	87	263,635		38,600	5,887	17
18	26	Insurance - Property & Contents	Resident Days (Total)	1,728,555	87	1,210,642		38,600	27,035	18
19	26	Insurance - Other	Resident Days (Total)	1,728,555	87	10,924		38,600	244	19
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	87	330,015		38,600	7,369	20
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	87	1,156,469		38,600	25,825	21
22	21	Management Fees	Resident Days (Total)	1,728,555	87	1,721,509		38,600	38,443	22
23	19	Legal Fees	Resident Days (Il Only)	675,434	31	13,948		38,600	797	23
24	22	Workers Compensation Claims	Resident Days (Il Only)	675,434	31	1,320,062		38,600	75,439	24
25	TOTALS					$ 9,512,806	$		$ 278,412	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 3395 North Pines Drive, Suite 102
City / State / Zip Code: Wilson, Wyoming, 83014
Phone Number: (307) 739-1209
Fax Number: (307) 739-1217

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Management Fees	Resident Days (Il Only)	675,434	31	$ 500,000	$	38,600	$ 28,574	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 500,000	$		$ 28,574	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC Comm. Mtg. Corp.		X	ACQUISITION	$16,717.00	02/06/98	$ 2,411,646	$ 2,257,571	02/01/08	0.0681	$ 160,141	1
2	CCS Note		X	ACQUISITION	$622.00	02/06/98	106,710	106,710	02/06/08	0.0700	12,691	2
3	See Attachment		X	ACQUISITION	$622.00	02/06/98	106,710	106,710	02/06/08	0.0700	12,691	3
4	Bank of New York		X	ACQUISITION	$26,193.27	05/01/79	2,172,740	1,833,333	05/01/10	0.0825	36,194	4
5												5
	Working Capital											
6	Health Care Financial Partners		X	WORKING CAPITAL	NONE	2/6/98	124,273	45,327	Demand	Prime +2%	36,194	6
7												7
8												8
9	TOTAL Facility Related				$44,154.27		$ 4,922,079	$ 4,349,651			$ 257,911	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,922,079	$ 4,349,651			$ 257,911	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	40,660	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	53,467	2
3. Under or (over) accrual (line 2 minus line 1).	$	12,807	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	41,549	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $0 **For** 19 00 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	54,356	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	53,460	8
	1996	54,312	9
	1997	52,236	10
	1998	52,999	11
	1999	53,467	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,875 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	362,419	1998	$ 35,152	1
2					2
3	TOTALS	362,419		$ 35,152	3

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Leasehold Improvements (Purchase Price)			1998	228,513	18654	12	18654		54,408	10
11	Leased Building (Purchase Price)			1998	1,998,252	163123	12	163123		475,774	11
12	Land Improvement			1998	14,668	978	20	978		2,852	12
13	Flag Pole			1998	667	33	10	33		83	13
14	Landscaping			1998	1,248	125	15	125		311	14
15	Resurface Parking Lot			1998	35,386	4423	8	4423		9,952	15
16	Hot Water Tank			1998	1,975	198	10	198		576	16
17	Boiler Repair			1998	1,307	108	12	108		297	17
18	Roof Vent			1998	937	79	11	79		203	18
19	100 Series Tackboards			1998	1,870	157	11	157		405	19
20	u-2 Sound Divider			1998	3,768	377	10	377		942	20
21	Interior Door Closer			1998	694	59	11	59		143	21
22	New Doors			1998	6,565	563	11	563		1,313	22
23	Repair Fire Wall Bath			1998	6,059	519	11	519		1,212	23
24	Repair Fire Wall			1998	2,100	173	11	173		489	24
25	Install Sink Disposal			1998	2,672	534	12	534		1,202	25
26	B Series Reverse Osmosis System			1998	4,412	441	5	441		993	26
27	Paint Remodel - Therapy Room			1998	191	38	10	38		83	27
28	Signage			1998	464	46	5	46		120	28
29	Track 12 x 8 w/ 90 degree bend			1998	64	6	10	6		12	29
30	Sign Posts, outside signs			1998	745	75	11	75		174	30
31	Panic Bars & Extension Rods			1998	1,300	114	10	114		237	31
32	Borders - Therapy Rm Remodel			1998	249	22	11	22		45	32
33	Remodel Therapy Room			1999	5,105	340	11	340		652	33
34	Drapery			1999	150	15	10	15		28	34
35	Wall Mural			1999	500	100	5	100		183	35
36	TOTAL (lines 4 thru 35)				$ 2,319,861	$ 191,300		$ 191,300	$	$ 552,689	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Office Carpets			1999	1,481	296	5	296		543	9
10	Carpets			1999	1,481	296	5	296		518	10
11	Carpets			1999	1,106	221	5	221		313	11
12	Covebase for carpet installation			1999	230	46	5	46		65	12
13	Vinyl Floor			1999	280	28	10	28		40	13
14	Door Alarm			1999	639	64	10	64		112	14
15	Door Alarm			1999	7,516	752	10	752		1,315	15
16	Wallpaper			1999	976	195	5	195		277	16
17	Wallpaper			1999	632	126	5	126		179	17
18	Door Alarm			1999	4,475	448	10	448		485	18
19	Door Alarm			1999	203	20	10	20		22	19
20	Plumbing Repair			1999	647	32	20	32		40	20
21	Refrigerator			1999	486	48	10	48		57	21
22	Cabinets			1999	8,668	578	15	578		674	22
23	Building Improvements-CK			2000	4,801	107	15	107		107	23
24	Building Improvements - INV			2000	806	18	15	18		18	24
25	Wallpaper & Border			2000	1,435	191	5	191		191	25
26	Wallpaper & Border			2000	764	76	5	76		76	26
27	Install AOS 400 gallon storage tank			2000	5,985	499	7	499		499	27
28	Boiler Repairs			2000	1,657	284	7	284		284	28
29	Install Tjerlund motor and wheel on power unit			2000	1,119	240	7	240		240	29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 45,387	$ 4,565		$ 4,565	$	$ 6,055	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 251,350	$ 34,881	$ 34,881	$	Various	$ 95,274	37
38	Current Year Purchases	1,104	74	74		Various	74	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 252,454	$ 34,955	$ 34,955	$		$ 95,348	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,652,854	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 230,820	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 230,820	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 654,092	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,962 Description: 900 Dishwasher, 374 Scaffolding, 2,688 Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts			1,307	33,843		35,150	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): ANCILLARY SUPPLI	39.2,39.3				8,330	48,155		56,485	13
14	TOTAL			$		$ 9,637	$ 81,998		$ 91,635	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,950	$	1
2	Cash-Patient Deposits	30,021		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	361,100		3
4	Supply Inventory (priced at cost)	30,793		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,866		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 437,730	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,152		13
14	Buildings, at Historical Cost	2,313,279		14
15	Leasehold Improvements, at Historical Cost	51,968		15
16	Equipment, at Historical Cost	252,455		16
17	Accumulated Depreciation (book methods)	(654,092)		17
18	Deferred Charges	2,023,888		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,022,650	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,460,380	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 433,922	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,021		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	41,549		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany SLP Texas	1,283,010		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,788,502	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,349,651		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,349,651	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,138,153	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,677,773)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,460,380	$	48

***(See instructions.)**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,168,303)	1
2	Restatements (describe):		2
3	AUDIT ADJUSTMENTS	(305,383)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,473,686)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,087)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (204,087)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,677,773)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (3,618,878)	1
2	Discounts and Allowances for all Levels	526,924	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (3,091,954)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(250,063)	6
7	Oxygen	(33,817)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (283,880)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(721)	13
14	Non-Patient Meals	(7,447)	14
15	Telephone, Television and Radio	54	15
16	Rental of Facility Space		16
17	Sale of Drugs	(72,483)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(12,801)	19
20	Radiology and X-Ray	415	20
21	Other Medical Services	(21,981)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (114,964)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other Misc Revenue**	(1,494)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,494)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ (3,492,292)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	761,754	31
32	Health Care	1,247,687	32
33	General Administration	491,425	33
	B. Capital Expense		
34	Ownership	994,078	34
	C. Ancillary Expense		
35	Special Cost Centers	91,635	35
36	Provider Participation Fee	109,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,696,379	40
41	**Income before Income Taxes (line 30 minus line 40)****	204,087	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 204,087	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Extended If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,959	2,286	39,150	17.13	2
3	Registered Nurses	7,498	8,748	134,218	15.34	3
4	Licensed Practical Nurses	22,200	25,900	267,158	10.31	4
5	Nurse Aides & Orderlies	49,005	57,173	475,022	8.31	5
6	Nurse Aide Trainees	150	175	989	5.65	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			2,012		8
9	Activity Director	1,969	2,297	22,269	9.69	9
10	Activity Assistants	2,280	2,660	15,014	5.64	10
11	Social Service Workers	3,496	4,079	40,450	9.92	11
12	Dietician					12
13	Food Service Supervisor	2,294	2,676	19,987	7.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,293	23,675	147,306	6.22	15
16	Dishwashers					16
17	Maintenance Workers	3,202	3,736	37,450	10.02	17
18	Housekeepers	12,525	14,613	79,115	5.41	18
19	Laundry	8,436	9,842	69,295	7.04	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	6,760	7,887	78,820	9.99	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,536	1,792	24,716	13.79	31
32	Other Health Ca MDS/MMQ	513	765	8,917	11.66	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,116	168,304	$ 1,461,888 *	$ 8.69	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,908	1.3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	300	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	32,866	10(a).3	40
41	Occupational Therapy Consultant	Monthly	34,361	10(a).3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	6,977	10(a).3	43
44	Activity Consultant	Monthly	2,290	11	44
45	Social Service Consultant	Monthly	2,290	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 85,992		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Contracted Service - Business Office	$ 38,553
Contracted Service - Administrator	30,708
TOTAL (agree to Schedule V, line 17, col. 3)	$ 69,261
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 1,086
Various	Accounting Fees	2,795
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,881

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,918
Unemployment Compensation Insurance	16,224
FICA Taxes	97,931
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	137
Health & Dental	25,825
TOTAL (agree to Schedule V, line 22, col.8)	$ 232,035

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,954
Health Care Worker Background Check	125
(Indicate # of checks performed)	
Advertising - Public Relations	17,005
Professional Dues / Licenses	1,407
Less: Public Relations Expense	(17,005)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,486

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	17,346
Seminar Expense	536
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,882

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER **#** 0043711 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **12**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **109,800**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **7,447**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **IMMATER**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **NO-MINOR**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.